Pulmonology Scenarios

Scenario 1 of 6:
Chief Complaint: Dyspnea

HPI: A 26-year-old male, who is new to this area, presents for intermittent cough and wheezing. Current symptoms began after an upper respiratory infection 5 months ago and are now worse with the colder autumn air and now also occur more frequently with exercise. He has even awakened with wheezing several times this last month.

Past Medical History: Childhood asthma, on meds, never hospitalized. No medications or symptoms for years.

Review of Systems: As above.

Physical Exam: Vital signs WNL. Cardiovascular exam has regular rate without murmurs. Pulmonary exam with coarse breath sounds all fields but no distinct wheeze or rhonchi. CXR is clear. Office spirometry has FEV 1 = 65% of predicted which improved to 80% post albuterol.

Assessment and Plan: Persistent asthma –inhaled albuterol as needed, return for further evaluation in one month.

Scenario 2 of 6:
Reason for Visit: Follow-up and medical management

HPI: A 60-year-old female with a history of COPD presents with complaints of continued shortness of breath and chronic cough productive of thick white sputum. She notes she is using her rescue inhaler more and thinks she is more out of breath with exercise. Patient denies chest pain, diaphoresis, orthopnea, PND or edema.

Past Medical History: COPD, on albuterol inhaler. Smoked 1ppd x 42 years, quit one year ago.

Review of Systems: As above.

Physical Exam: Thin elderly appearing female in no acute distress. BP= 128/82, P= 72, RR= 17, SPO= 95% on room air. Cardiovascular exam is WNL, Pulmonary exam has decreased, coarse BS in all fields, no rhonchi or wheezing. CXR has flattened diaphragms and hyperinflation without infiltrates or effusions. FEV1/FVC ratio is 67%, FEV1= 70% on office spirometry.

Assessment and Plan: Moderate COPD add long acting anticholinergic, continue albuterol.

Scenario 3 of 6:
Emergency Department Services

HPI: Patient is a 24-year-old female with a history of asthma presents to the ER complaining of 3 days of worsening respiratory symptoms. She has increasing SOB, no chest pain, no productive cough, and no fever. She has awakened the last two mornings with wheezing only partially relieved with inhalers.

Past Medical History: Asthma, on inhaled steroids. Previously hospitalized and intubated.

Review of Systems: As above.

Physical Exam: Thin young female in moderate respiratory distress. Afebrile, RR= 26. Patient is unable to talk in complete sentences, she is using accessory muscles to breathe. Breath sounds are distant with minimal wheezing in all fields.

CXR is negative for infiltrates.

ED Course: Nebulizer treatments, IV steroids with improvement in respirations. Patient has decreased use of accessory muscles and is able to complete sentences. There is increased wheezing on exam.

Clinical Impression: Asthma exacerbation

Disposition: Admit to ICU for observation and continued nebulizer treatments, steroids.

Scenario 4 of 6:
Chief Complaint: Progessive dyspnea

HPI: Patient is a 68-year-old man who presents with complaints of dry cough and worsening shortness of breath over the last two years. He denies fever, night sweats, weight loss or hemoptysis. No chest pain or diaphoresis. No rhinorrhea.

Past Medical History: Smoked 1/2ppd x 15 years, quit 30 years ago Worked as a pipefitter for 40 years.

Review of Systems: As above.

Physical Exam: RR= 18, BP= 130/75. Pulmonary exam is significant for bilateral dry crackles and diminished inspiration. PFTs have decreased FVC, TLC, DLCO and FRC. CXR is significant for partially calcified pleural plaques and interstitial fibrosis.

Assessment and Plan: Asbestosis, begin supplemental oxygen

Scenario 5 of 6:
Chief Complaint: Progessive dyspnea

HPI: A 50-year-old female presents with complaints of increasing shortness of breath for 6 months. At first, symptoms only occurred while jogging on her treadmill. She stopped the jogging when she became dizzy along with the SOB, sometimes feeling like she would pass out. Now symptoms can occur with walking or doing household activity. They are relieved with rest. She denies cough, chest pain or palpitations. No fever.

Past Medical History: As above. No medications. Non-smoker. Denies illicit drug use.

Review of Systems: As above.

Physical Exam: Afebrile, BP= 110/65, RR= 22, P= 100. Moderately obese female in no acute distress. Cardiovascular exam is significant for a loud P2, fixed split S2 and a 2/6 holosystolic murmur at the left sternal border. A V/Q scan has a moth eaten pattern. CXR shows enlarged pulmonary arteries, with a prominent right atrium and ventricle.

Assessment and Plan: Pulmonary HTN, order TEE and begin phosphodiesterase therapy.

Scenario 6 of 6:
Chief Complaint: Continued cough and fever post antibiotics

HPI: A 60-year-old male presents for follow up continuing to complain of nonproductive cough, fatigue, shortness of breath and subjective fever. He also wakes up at night sweating and by the office scales has lost 5lbs. Symptoms started about 5 weeks ago and have not improved with antibiotics which patient states he completed.

Past Medical History: As above. His annual work physical which included labs, EKG and CXR were completed and normal 6 months ago. Non-smoker, denies illicit drug use. He is married and monogamous. No new pets or recent travel.

Review of Systems: As above.

Physical Exam: BP= 128/82, P= 85, RR= 18, T= 100. Cardiovascular exam is WNL without murmur, no JVD. Respiratory exam is significant for scattered crackles bilaterally without evidence of focal consolidation. CXR shows bilateral patchy alveolar opacities, no effusion

Assessment and Plan: Cryptogenic organizing pneumonia, schedule bronchoscopy, start steroids